Boulder Community Health

Outpatient Rehabilitation Services

Speech-Language-Cognitive Therapy

Adult Patient Intake Questionnaire

Name: _____ Date of Birth: _____
Today's Date: _____ Age: _____
Referring Physician: _____ Primary Dr: _____
Neurologist: _____ Physical Therapist: _____

1. How would you describe your health today? ❒ *Excellent* ❒ *Very Good* ❒ *Fair* ❒ *Poor*

2. What treatment have you received since the onset of difficulties? (Please list hospitalizations, healthcare providers or therapists as best as you can) _____

_____

_____

3. Diagnostic Tests:
   ❒ *CT* ❒ *MRI* ❒ *Xray* ❒ *Swallow Test* ❒ *Endoscopy* ❒ *Neuropsychological Test*
   Other: _____

4. Do you have any other medical problems? ❒ *Yes* ❒ *No*
If yes, please explain: _____

_____

5. Significant surgical history: _____

_____

6. Allergies (Drug, Food, Environmental): _____

_____

7. Current medications and supplements: _____

_____

_____

8. What are your <u>specific goals</u> for speech-language-cognitive therapy?

_____

_____

9. Are you 65 or older? ❒ *Yes* ❒ *No*
10. Have you had 2 or more falls in the past year? ❒ *Yes* ❒ *No*
11. Have you had any injury from a fall in the past year? ❒ *Yes* ❒ *No*

_____
Patient Label or Name and DOB

Speech/Language- Please check the box if you are having challenges in any of these areas:

- ❑ decreased articulation
- ❑ decreased coordination to produce words
- ❑ difficulty naming
- ❑ pragmatics: *e.g*. using the appropriate tone & volume, taking turns, etc.
- ❑ slurred speech
- ❑ spelling
- ❑ stuttering
- ❑ reading comprehension
- ❑ weakness - mouth
- ❑ weakness - lips
- ❑ word retrieval
- ❑ writing
- ❑ unable to follow directions or understand conversations
- ❑ voice changes (quality, volume, hoarseness, etc.)
- ❑ other _____

Cognitive:

- ❑ attention/concentration
- ❑ cognitive overwhelm
- ❑ fatigue
- ❑ goal-setting
- ❑ information processing
- ❑ limit-setting
- ❑ memory- long term
- ❑ memory – short term
- ❑ multitasking
- ❑ organization
- ❑ pacing and prioritizing
- ❑ problem solving
- ❑ return to work
- ❑ return to school
- ❑ self awareness
- ❑ task initiation and completion
- ❑ time management
- ❑ verbal expression
- ❑ other _____

Please describe how you were doing before the onset of these problems: _____

_____

_____

❒ *Right handed* ❒ *Left handed*

Home/ Social/ Community

1. Home Situation: ❒ *house* ❒ *apartment* ❒ *condo/townhome*
2. Where:
   ❒ *Boulder* ❒ *Broomfield* ❒*Lafayette* ❒ *Louisville* ❒*Erie* ❒ *Other:* _____
3. Relationship status: ❒ *single* ❒ *married* ❒ *divorced* ❒ *dating*
4. Who do you live with? _____
5. Children: ❒ *Yes* ❒ *No* Grandchildren: ❒ *Yes* ❒ *No*
6. Pets:_____
7. Do you feel safe at home? ❒ *Yes* ❒ *No*

_____
Patient Label or Name and DOB

Education/Occupation

1. Are you currently working or going to school? ❒ *Yes* ❒ *No* ❒ *Retired* ❒ *On Disability*
2. Education : ❒ *GED* ❒*high school* ❒*some college* ❒ *Bachelor's* ❒ *Master's* ❒ *PhD* ❒ *Tech/Vocational*
3. What is/was your area of study? _____
   _____
4. Learning Style: ❒ *Doing* ❒ *Visual* ❒ *Listening* ❒ *Reading/Written handouts*
5. What do you do for work? _____
6. How many hours do you work per week? _____
7. Did you take any time off from work? ❒ *Yes* ❒ *No*
   If yes, how long? Why? _____
   _____
   _____
8. Do you volunteer? Describe:
   _____
9. Hobbies/Interests/Social Life: _____
   _____
   _____
10. What do you do for exercise? _____
11. How often? _____

Physical:

- ❑ decreased balance
- ❑ decreased endurance
- ❑ headaches
- ❑ Jaw pain/TMJ
- ❑ nausea
- ❑ pain
- ❑ paralysis
- ❑ vertigo (dizziness)

Psychosocial/Emotional:

- ❑ anxiety
- ❑ anger control/temper outbursts
- ❑ change in sex drive
- ❑ depression
- ❑ driving anxiety
- ❑ flashbacks
- ❑ easily upset or angry, cries easily
- ❑ frustration
- ❑ grief and loss issues
- ❑ irritability
- ❑ panic attacks
- ❑ relationship difficulties
- ❑ sleep problems
- ❑ stress

1. Who is part of your support system?
   _____
   _____

_____
Patient Label or Name and DOB

2. How are they helping you?

_____

_____

Have you participated in mental health therapy or counseling before? ❒ *Yes* ❒ *No*

Home Management:

Check challenging home tasks:

- ❑ Childcare
- ❑ Cleaning
- ❑ Cooking
- ❑ Grocery shopping
- ❑ Laundry
- ❑ Paperwork
- ❑ Medication management

Who is helping you with your challenges? _____

Sleep:

Check the words that describe your sleep

- ❑ No problems
- ❑ Awaken fatigued
- ❑ Difficulty falling asleep
- ❑ Intermittent awakening
- ❑ Insomnia
- ❑ Nightmares
- ❑ Restless sleep
- ❑ Other:_____

1. Do you take sleep medication? If so, what do you take? _____
2. Do you take naps? ❒ *Yes* ❒ *No* How many per day?_____
3. Have you been diagnosed with: ❒*Sleep Apnea* ❒*Narcolepsy*
4. How many hours of sleep do you usually get? _____
5. What time do you usually go to bed?_____What time do you wake up?_____

Appetite:

Check all that apply:

- ❑ Same – no problems
- ❑ No appetite
- ❑ Increased appetite
- ❑ Decreased appetite
- ❑ Forget to eat
- ❑ Gained weight
- ❑ Lost weight
- ❑ Decreased sense of taste or smell
- ❑ Special diet: _____
- ❑ Other: _____

# of meals/day_____ # of snacks_____

Substance Use:

1. # Caffeinated drinks_____
2. Do you drink alcohol? ❒ *Yes* ❒ *No*

   If yes: # of alcoholic drinks _____ ❒ *Per day* ❒ *Weekly* ❒ *Socially*
3. Do you smoke tobacco? ❒ *Yes* ❒ *No*
4. Do you use any recreational drugs? ❒ *Yes* ❒ *No*

   How often? _____

_____

Patient Label or Name and DOB

Hearing

Check all that apply:

- ❑ No difficulties
- ❑ Tinnitus/ringing in the ears
- ❑ Sensitivity to noise
- ❑ Decreased hearing acuity
- ❑ Decreased auditory processing

Do you wear hearing aids? ❒ *Yes* ❒ *No*
Do you wear them consistently? ❒ *Yes* ❒ *No*
Do they help you? ❒ *Yes* ❒ *No*

Vision

Check all that apply:

- ❑ Glasses for reading
- ❑ Glasses for vision
- ❑ Contact lenses
- ❑ No difficulties
- ❑ Blurry vision
- ❑ Sensitivity to light
- ❑ Double vision
- ❑ Decreased peripheral vision
- ❑ Headaches with reading
- ❑ Decreased tracking abilities

Driving/Transportation

Do you have any difficulties with driving? ❒ *Yes* ❒ *No*
If yes, please explain: _____
_____

Cultural/Spiritual Concerns

Do you have any cultural or spiritual concerns that we should consider during your therapy? _____
_____

_____
Patient Signature **Date/Time**

Thank you! Please turn this questionnaire in to the Outpatient Rehabilitation check in desk during the check in process the day of your evaluation.

_____
Patient Label or Name and DOB